

# U.S. Department of Justice Investigation of a State Psychiatric Hospital

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The Department of Justice investigation of state psychiatric hospitals is nothing like investigation by more familiar regulatory agencies such as The Joint Commission or Centers for Medicare and Medicaid Services (CMS). For one, it comes with the threat of serious legal consequences for both the state psychiatric hospital under investigation and the state in general. Although little has been written about this topic, much of what has been written describes a negative, painful, and expansive experience affecting every aspect of the hospital system. Using an example of a state psychiatric hospital that has been investigated by the DOJ, this article examines this portrayal and explores whether there are positive aspects of such investigations that have been overlooked.

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On May 30, 2006, the United States Department of Justice (DOJ) commenced an investigation into allegations that Connecticut Valley Hospital (CVH), one of the hospitals of the Connecticut Department of Mental Health and Addiction Services (DMHAS), violated the Civil Rights of Institutionalized Persons Act (CRIPA).<sup>1</sup> A site visit was subsequently conducted and in August 2007, the DOJ released their findings documenting deficiencies in multiple areas of clinical care, practice, and safety.<sup>2</sup> Specifically, the DOJ consultants noted that certain conditions and services at CVH substantially departed from generally accepted standards, and violated the constitutional and federal

statutory rights of patients in the areas of protection from harm and undue restraints, psychiatric and psychological services, and discharge planning and placement in the most integrated setting appropriate to each patient's individualized needs.<sup>2</sup>

Over the next two years, the state negotiated a settlement agreement with the DOJ that was signed in July 2009.<sup>3</sup> The settlement agreement was separated into sections, including Integrated Treatment Planning, Mental Health Assessment, Discharge Planning and Community Integration, Psychiatric and Psychological Treatment Services, Documentation, Seclusion and Restraint, Protection from Harm, and Suicide Prevention. Each section contained elements that needed to be met within a specified time frame. Overall compliance with the settlement agreement was expected within a four-year time frame.

The state of Connecticut (CT) and the DOJ agreed that a designated consultant would be hired, at the expense of the state, to conduct site visits every six months and report on the progress toward compliance. Prior to each site visit, the hospital submitted information about the changes in policy, procedure, or practice, as well as data to demonstrate efforts toward compliance. That information was then reviewed and validated during the on-site visit. Recommendations

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were made and a compliance rating was provided for each element.

The challenges and negative reactions toward and outcomes of DOJ investigations of state hospital facilities have been documented in the past.<sup>4</sup> This article describes the experience of the state of Connecticut with the implementation of a settlement agreement with the DOJ related to allegations of civil rights violations, with a focus on identifying benefits, if any, of implementing the settlement agreement.

### Historical Perspective

From their creation in the 19th century until the 1950s, asylums operated with independence and limited scrutiny from state and federal authorities.<sup>5</sup> A confluence of factors led in the 1940s and 1950s to exposés about working and living conditions in psychiatric hospitals. These factors include the presence of conscientious objectors assigned to work in psychiatric hospitals during World War II,<sup>6</sup> journalists documenting that work, and sociologists such as Erving Goffman, who documented the inner workings of a public psychiatric hospital in his book *Asylums*.<sup>7</sup> The 1950s and 1960s saw the emergence of the civil rights movement and the passage of the Civil Rights Act.<sup>8</sup> These factors contributed to deinstitutionalization of state psychiatric hospitals that began in the late 1960s as an outgrowth of the National Mental Health Act of 1946.<sup>9</sup> State hospitals were closed, and patients were placed in outpatient settings and received care in community mental health centers, in part because the federal government agreed to pay more than 50 percent of the cost of care in outpatient settings. The DOJ became involved in concerns related to mental health care delivery in the 1970s, primarily in the form of *amicus curiae* briefs. For instance, in *Wyatt v. Stickney*<sup>10</sup> the DOJ joined other organizations in submitting *amici curiae*<sup>11</sup> supporting the notion that involuntarily committed patients in state institutions have a constitutional right to receive individualized treatment.

The initial efforts of the DOJ to influence inpatient care delivery had limited success. In two lawsuits regarding individuals with developmental disabilities,<sup>12–14</sup> the courts ruled that the DOJ had no standing in the suits. Further, a 1977 bill before Congress aimed at empowering the DOJ to investigate psychiatric facilities failed to pass.<sup>15</sup> Things changed when President Carter signed the Civil Rights of Institutionalized Persons Act<sup>1</sup> into law, giving the DOJ the

authority to investigate jails, prisons, juvenile detention facilities, facilities for individuals with developmental disabilities, nursing homes, and psychiatric hospitals. It is enforced by a Special Litigation Section of the USDOJ Civil Rights Division which investigates if there is a pattern or practice of violations of the federal rights of people housed in the institutions mentioned earlier. Embedded in CRIPA, however, were limitations of the scope of investigative and adjudicative authority, for instance, language favoring remediation over litigation.

More recently, DOJ investigations have also included a focus on prompt discharge of patients from the hospital to the least restrictive and most integrated setting, thereby invoking the 1999 *Olmstead* decision. In *Olmstead v. L.C.*,<sup>16</sup> the U.S. Supreme Court held that under the Americans with Disabilities Act,<sup>17</sup> individuals with mental disabilities have the right to live in the community rather than in institutions if the state's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities. The enforcement of *Olmstead* across the nation was uneven, however, causing the DOJ to increasingly champion its enforcement, especially after President Obama launched the Year of Community Living in 2009.<sup>18</sup>

With the power afforded by CRIPA, the DOJ started to investigate various state-run inpatient psychiatric facilities in the 1980s. The process involved experts hired by the DOJ to survey the institutions and to offer findings about their investigations. These experts' opinions, presented as Finding Letters,<sup>4</sup> contain allegations of civil rights violations at the facility that form the basis of the lawsuit that challenges the state regarding its management of the facility. The state must answer these allegations in federal court.

Much of the work of the DOJ received little scrutiny in the media in the 1980s. This changed in the 1990s after a series of exposés in the *LA Times* highlighting deplorable conditions in several California public mental health facilities.<sup>19</sup> Soon thereafter, the *Hartford Courant* published a series of articles that received national attention about patient deaths occurring during restraint episodes in mental health institutions.<sup>20</sup> Connecticut U.S. Senators Dodd and Lieberman drafted a bill, approved by Congress, prohibiting

the use of restraints except when needed to protect the patient, staff, or other residents of the facility.<sup>21</sup>

In the 1990s and 2000s, the DOJ multiplied efforts to challenge states in their management of inpatient mental health care and other facilities, such that at the end of Fiscal Year 2015, there were active CRIPA cases in 150 facilities in 27 states, the District of Columbia, the Commonwealth of Puerto Rico, and the Territories of Guam and the Virgin Islands.<sup>22</sup> Only three of the facilities under investigation were mental health facilities. States taken to court by the DOJ over civil rights violations have adopted one of two main legal strategies. Some entered into litigation. Many settled because of the cost and uncertain outcome of litigation in the federal arena.<sup>4</sup>

### Regulation of State Psychiatric Hospitals

State psychiatric hospitals are monitored by regulatory bodies such as the state's licensing entity, the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), if they are TJC accredited. These agencies set regulations, conditions of participation, and standards of practice and operation. Notably, The Joint Commission has been granted deemed status<sup>23</sup> by the CMS. Deemed status is granted when an accreditation agency's standards meet or exceed the CMS conditions of participation.<sup>24</sup> Therefore, a hospital that is accredited by TJC does not have to undergo separate surveys from CMS. Hospitals pay TJC for their services to become accredited after meeting the conditions of participation. State hospitals are motivated to pursue and maintain CMS standards because certification provides access to federal funds. Hospitals failing to meet the established conditions of participation and accreditation standards must submit a plan of correction and undergo additional surveys to monitor compliance. Failure to achieve compliance within a specific timeframe could result in a loss of accreditation, CMS certification, and federal funding.

Monitoring of state hospitals by these agencies is ongoing for as long as the hospital chooses to participate; the regulatory agencies visit the hospitals at regular intervals to conduct accreditation surveys. These agencies may also conduct unannounced visits to perform investigations. Investigations may be triggered by adverse or sentinel events, complaints reported to the regulatory agency by hospital staff, patients or their family members, or advocates, or concerns reported in the media.

The DOJ performs a different kind of regulatory function altogether. It does not have an existing

relationship with the hospital being investigated, unlike the other entities. Although the triggers for DOJ investigation of a state hospital are the same as those for other regulatory agencies, the DOJ's process differs from others in a variety of ways (see Table 1). First, it is a legal process from the start and, as such, it immediately creates an adversarial relationship between the hospital staff and the DOJ attorneys or monitors. This could play out in a contentious interaction between hospital clinicians and clinicians hired by the DOJ. The legal process is resolved either through a settlement agreement by the court, or by a court trial and subsequent court order.

Second, the settlement agreement or court order specifies a time frame within which the hospital must correct the documented deficiencies for the DOJ monitoring to end, unlike other regulatory agencies that monitor hospitals for as long as the hospital voluntarily seeks accreditation or government funding. Once the DOJ determines a hospital has reached compliance with the settlement agreement or satisfied the court order, the DOJ will end the investigations and monitoring, declare that the hospital is now in good health, and depart. The DOJ may return at a later date in response to new complaints, but that would be a new legal process unattached to the previous investigation.

Third, the DOJ does not set or publish standards of practice that are uniformly embraced or adhered to by hospitals. During the course of the investigation or monitoring, they do not provide to state hospitals the standards on which they base their findings. Instead, they refer to the precedent set in *Youngberg v. Romeo*<sup>25</sup> that defers to (their) experts the authority of determining what acceptable standards of practice are.

In addition, the DOJ does not enforce these standards once the legal process ends. Notably, privately owned hospitals do not fit the definition of institution under CRIPA and therefore are not subject to investigation of potential CRIPA violation, nor the application of the standards of practice utilized by the DOJ. Both CMS and TJC certify and accredit state and private hospitals according to a published set of conditions of participation and standards that may be updated periodically based on advancements in science, technology, and practice.

Finally, the course of action for a state in response to DOJ findings of a violation is not predetermined. As previously stated, it follows a legal course that includes a settlement agreement, or a court trial. If a settlement

## Pain and Gain of U.S. DOJ Investigation of a State Psychiatric Hospital

**Table 1** Comparison of Regulatory/Monitoring Bodies

Monitoring Agency	CMS <sup>a</sup>	TJC <sup>b</sup>	DOJ <sup>c</sup>
Investigation triggered by a Sentinel Event	Sometimes	Sometimes	Always
Routine and ongoing survey as part of conditions of participation	Yes	Yes	No
Compliance with federal regulatory standards for hospitals	Sets and ensures compliance with conditions of participation	Meets or exceeds CMS conditions of participation through establishment of elements of performance	Establishes own standards
Participation	Voluntary	Voluntary	Involuntary
Effect of hospital's certification	Deems hospital eligible to receive Medicare and Medicaid reimbursements	Deems hospital eligible to receive Medicare and Medicaid reimbursements	Prevents closure of hospital
Hospital Expenses	No payment for regulation	Pays TJC a fee to be included in the survey process	Pays DOJ consultants for ongoing monitoring of process until compliance with settlement agreement is reached
Regulatory or survey process	Collaborative	Collaborative	Adversarial
Attorneys as part of team of investigators/surveyors	No	No	Yes
Investigation or survey based on court order or settlement agreement	No	No	Yes
Finite period of investigation or survey known at start	Yes	Yes	Yes
State and privately owned hospitals affected	Yes	Yes	No (only state hospitals)
Survey initiated as a result of a complaint	Yes	Yes	Yes

<sup>a</sup>CMS: Centers for Medicare and Medicaid Services.

<sup>b</sup>TJC: The Joint Commission.

<sup>c</sup>DOJ: Department of Justice.

agreement is reached, the state has specific performance measures to meet within a negotiated timeframe, often lasting several years. It is during this time that the state and DOJ must agree on a monitor or consultant who, at the state's expense, will be responsible for conducting regular monitoring visits to evaluate the degree of progress toward meeting compliance with the terms of the settlement agreement. There is further variability in the process depending on the approach of the chosen monitor or consultant.

### Hospital's Response and Staff's Reactions

At the time of the DOJ investigation and monitoring, CVH was a 615-bed public sector psychiatric hospital of the state of Connecticut comprising 27 units or wards within three divisions: Forensic, Addictions, and General Psychiatry. The General Psychiatry Division had geriatric and traumatic brain injury units, in addition to intensive therapy units serving patients with severe suicidal and nonsuicidal

self-injury, aggressive behaviors, and refractory severe mental illness. In May 2018, the Forensic Division of CVH was officially separated from CVH and Whiting Forensic Hospital was formed. Whiting Forensic Hospital consists of 91 maximum security beds and 138 enhanced security beds.

Connecticut responded to the DOJ findings by negotiating a settlement agreement and hiring a mutually agreed upon designated consultant to monitor the hospital's progress toward compliance. The settlement agreement consisted of 79 items divided into twelve sections. There were 59 measures located in eight sections that required a detailed response with data to substantiate compliance with all parts of the measures. Many of these 59 measures had multiple parts (A, B, C, and so on). For example, under the section titled Psychiatric and Psychological Treatment Services, there are thirteen measures, one of which is detailed in Table 2.

These measures were evaluated and rated as non-compliance, partial compliance, or substantial compliance following a site visit every six months.<sup>3</sup> In

**Table 2** Example of Psychotropic Medication Use Measure from Settlement Agreement<sup>3</sup>

By 18 months from the effective Date hereof, CVH<sup>a</sup> shall develop and implement policies and/or guidelines to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and/or guidelines shall address:

- A. monitoring of the use of psychotropic medications to ensure that they are: 1.) specifically matched to current, clinically justified diagnoses; 2.) prescribed in therapeutic amounts, as dictated by the needs of the individual patient; 3.) tailored to each individual's clinical needs; 4.) monitored for effectiveness against the objectives of the individual's treatment plan; 5.) monitored appropriately for side effects; and 6.) properly documented;
- B. monitoring of the use of PRN medications to ensure that these medications are clinically justified and administered on a time-limited basis, and not used as a substitute for adequate treatment of the underlying cause of the individual's condition;
- C. monitoring of the use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks;
- D. appropriate use of psychotropic medications with attention to side effects;
- E. timely identification, reporting, data analyses, and follow up remedial action regarding adverse drug reactions reporting ("ADR");
- F. drug utilization evaluation ("DUE") in accord with established, up-to-date medication guidelines;
- G. documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR");
- H. tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR;
- I. feedback to the practitioner and educational/corrective actions in response to identified trends, when indicated; and
- J. use of information derived from ADRs, DUE, MVR, and providing such information to the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees (Ref. 3, p 13–14)

<sup>a</sup>CVH: Connecticut Valley Hospital.

addition, information on the total number of staff by role or discipline was monitored at each visit.

**Data Collection**

The Commissioner of DMHAS designated a Project Director who was responsible for developing a structure and process to implement changes to achieve compliance. That process included designating persons responsible for each of the eight sections of the settlement agreement, implementing new hospital committees, and designing audit forms, with the ultimate goal of creating an infrastructure that connected all the required elements in a way that was seamless within ongoing hospital operations. The administrative leaders and staff received focused training on new policies and audits and the implementation of these changes with their staff.

**Hiring of Key Staff**

Prior to the settlement agreement being signed, the state made great efforts in hiring additional staff. Throughout the term of the settlement agreement, consistent focus was maintained on staffing to ensure key professional and support positions were filled to promote compliance with new policies, processes, and clinical requirements. Two areas stand out in this regard. The first was the need to hire more psychologists so that each unit had an assigned psychologist. There was also a need to hire psychologists with special training in behavioral assessments, plans, and

management. This was particularly important in the management of patients with extreme aggression and other serious behavioral dyscontrol. A centralized team of behavioral psychologists (called the Behavioral Intervention Service) was formed that responded to patients across all hospital units, serving as consultants in their care.

The second area was that of discharge planning. Additional social workers were hired to enhance discharge planning procedures and processes to meet the increased emphasis on discharging patients to the most integrated setting outside of the hospital. Much of the work in this area included discussions about risk and developing screening and assessment tools, revising unit programming schedules to include additional skills-based group therapies, case reviews with the DMHAS Medical Director for those individuals with the longest lengths of stay, and providing opportunities for the hospital staff to learn more about community treatment options. Funds were allocated by the state to develop additional community-based options for individuals to transition from the hospital.

**Staff Training and Monitoring of Progress**

Training needs were widespread across roles and disciplines. The DOJ consultants provided some training to psychologists prior to establishing the centralized behavioral intervention team. They also provided training to multidisciplinary staff on developing treatment plans with new requirements put in place. Most of the training that was needed was provided by hospital staff, staff

from the DMHAS Office of the Commissioner, or other external consultants identified as experts in a particular area.

Once processes were established and training commenced, a monitoring system was implemented to assess progress. Audit tools were developed to monitor compliance with documentation requirements regarding clinical care and safety measures across all disciplines. Audits were conducted through a peer-review process and the findings were analyzed by the appropriate discipline head. Identified deficiencies were corrected through feedback to the responsible clinician. The auditing process was extensive and exhaustive. The performance measures were monitored and discussed regularly in internal committee meetings and in six-month progress reports to the DOJ consultant. (An example of a progress report containing the measures monitored by the DOJ is available from the authors.) The monitoring was incorporated into the Quality Assurance and Performance Improvement system at the hospital. Corrective action plans were developed when monitoring showed a lack of progress, failure to meet the performance target, or the policy or approach was no longer appropriate or effective.

Early in the process, so many changes were being made simultaneously and in many different areas that it was difficult to see how they would make a difference in achieving compliance with the settlement agreement. Over time, however, the interconnectedness became more visible and ultimately a new infrastructure emerged. The ability to see how all the parts came together provided a greater sense of clear direction and confidence that the hospital could be successful in meeting the settlement agreement.

### **Staff Experience and Response**

The staff experience during this process was challenging. Initially, there were feelings of anger and defensiveness as their work was called in to question by outsiders. For example, some psychiatrists took offense to a DOJ consultant's (a psychiatrist) comments that psychiatric medications were poison while admonishing prescribers to be judicious in their use. Others expressed frustration that the DOJ consultants did not possess special qualifications or expertise to judge their clinical practice or make treatment or discharge recommendations. Many staff had worked with the patients for several years, deeply cared for their well-being, and were concerned that their needs would not

be met in the community if they were precipitously discharged as seemed to be the charge of DOJ consultants. Staff also worried about their patients' ability to maintain safety for themselves and the community.

With the implementation of many changes, the staff were often frustrated and confused by the volume of new information, perceived mixed messages, and with what appeared to be a randomness to the changes proposed by the DOJ. They complained that they were spending more time in documenting, charting, and auditing, and less time in personally interacting with their patients than they had done in the past. Once training was conducted and reinforced and they could begin to understand the connections better, some of the frustration subsided. For others, the process proved to be too much, and many staff moved on to opportunities both within and outside of the state system.

### **Monitoring of Adherence by DOJ Consultants**

The overarching principle that the DOJ consultants promoted was adherence to policies and procedures regarding psychiatric care consistent with what they termed "generally accepted professional standards of care." This principle was operationalized with great specificity. The consultants closely monitored the hospital documentation regarding delivered care. One example of these was response to medication, with special attention to side effects, timely review of as needed (or PRN) medications, and proper integration of psychological and behavioral treatment. For instance, close attention was paid to avoiding polypharmacy (which was broadly defined to include all psychotropic medications) and to ensuring proper clinical justification of the use of PRN medications. Regarding the latter, PRN medications were not to be used as a substitute for adequate treatment of the underlying cause of the individual's condition. These data were to be forwarded to the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.

Another example was the competent delivery of individual therapy, group therapy, and psychological assessments, along with enhanced competencies in behavioral treatment. Progress toward enhanced competencies was to include relevant training opportunities, monitoring that a sufficient number of psychologists were available to provide behavioral treatment and to ensure maximal access to psychological care, monitoring behavioral treatment plans for adherence to standards of

practice, and monitoring outcome of behavioral treatment. For instance, the group of patients provided with a behavioral treatment plan were monitored with respect to the percentages who clinically deteriorate, remain unchanged, or improve.

The degree of specificity of DOJ's expectations was high. The standards regarding behavioral treatment plans illustrate how the expectations were operationalized. All behavioral treatment plans were rated monthly for adherence to the following standards:

- Behavioral treatment plans outcome data are tracked, monitored, and analyzed.
- Behavioral interventions are comprehensive and staged properly.
- Behaviors of concerns (e.g., aggression towards self or others) are properly matched with reactive strategies.
- Reactive strategies are clear and well-formulated.
- All behavioral treatment plans are accompanied by a summary used to train nursing staff on ways to implement the plan.
- Positive behaviors (e.g., appropriate use of social skills, medication adherence, and healthy use of leisure time) are monitored and analyzed.

The hospital was also tasked with providing "appropriate meaningful" psychosocial rehabilitation services with the goal of promoting patients' ability to engage in more independent life functions, taking into consideration their strengths, preferences, and interests, as well as their vulnerability to substance use and to experiencing symptom exacerbations. The need to provide active treatment in the evening (outside of regular work hours) and on weekends and holidays was also emphasized, in part by assigning treatment roles to all hospital personnel. Group attendance was monitored, and for patients who did not attend scheduled groups, it was expected that alternative treatments be provided.

## Accomplishments

The hospital embarked on a methodology to reduce lengths of stay, which entailed identifying patients whose length of stay exceeded certain thresholds and systematically addressing the obstacles to their discharge. These tasks were addressed systematically using objective data. A sophisticated system to address risk was developed. A team of specially trained psychologists was formed to address behavioral excesses such as aggression or inappropriate sexual behaviors. They developed positive behavioral support plans, the implementation of which was monitored closely for fidelity to the plans. The psychologists trained the clinical and

direct care staff to implement the plan and document the individual response to the interventions.

Opportunities for community living for patients with higher level of psychiatric symptomatology than typically handled in the community were created *de novo*, at great expense to the state. For instance, DMHAS created a home for women with severe mental illness who are trauma survivors and a home for older men with medical co-morbidities. These homes included on-site staff to support the discharged patient's transition and life in the community.

Databases were created for all these goals and accumulated data were reviewed monthly and analyzed to provide answers to the numerous questions posed by the DOJ. The status of patients with long lengths of hospital stay was reviewed periodically by the medical leadership. Identified needs that could not be met with available resources were communicated to the hospital leadership and the DMHAS medical director in order that systemic solutions can be identified.

Reducing the length of stay requires sufficient personnel to complete all necessary tasks to accomplish this goal. At the outset of this project, the need to recruit additional social workers, psychologists and occupational therapists was identified and met. This higher psychology staffing level enabled the examination of all patients, especially newly admitted individuals, for the need for targeted behavioral plans, and the creation of behavioral support plans or guidelines for all individuals who need them. Similarly, a higher social work staffing level made it possible to address discharge needs with a focus on creative solutions to identify or modify discharge sites and recommend development of specialized homes. The higher occupational therapists (OT) staffing level enabled the development of treatment plans with comprehensive OT assessments that included sensory integration practices. They also identified a patient's skill set or deficits to better match patients with appropriate community placements.

Prior to the arrival of the DOJ, the hospital had introduced several quality-of-care initiatives that the DOJ subsequently encouraged, closely monitored, and evaluated. These included the creation of comfort rooms throughout the hospital and the execution of sensory modulation initiatives (training, assessment, and interventions), and the implementation of the Six Core Strategies for Reducing Seclusion and Restraint published by the National Association of State Mental Health Program Directors (NASMHPD).<sup>26</sup> In 2007, DMHAS was awarded a grant from NASMHPD to

participate in their Alternatives to Restraint and Seclusion State Incentive Grant,<sup>27</sup> a national initiative to reduce restraint and seclusion use.

The mechanism of review of all patients with long lengths of stay or assessed to be at high risk from a medical or psychiatric perspective was performed at several levels within the hospital. To ensure adherence to the newly created routinized processes, two levels of monitoring were used: one by peers and the other by clinical managers. These two levels of monitoring were complementary. The former ensured adherence to professional standards regarding admission data collection, multidisciplinary assessment, medication monitoring, attendance at therapeutic activities, discharge planning, etc. The latter focused on clinical outcomes.

A committee infrastructure was also established, and a process was developed. There were three possible levels of review; first, at the local level by the clinical leadership of the hospital division, and second, if needed, by the hospital clinical leaders at large. If challenges persisted despite these reviews, the patient was presented to the DMHAS medical director for additional consultation and, in some cases, approval of additional resources, including use of national consultants, to manage identified challenges. This made it possible to identify unique needs related to the reduction of lengths of stay. For instance, obstacles to implementation of specialized plans were recognized and mitigation strategies developed. These interventions yielded positive results as discharges from the General Psychiatry Division improved by 523 percent from 2009 to 2013 when compliance with the settlement agreement was achieved.

### **Lessons Learned**

One of the most significant benefits of the DOJ oversight was instilling the value of using data to inform decision-making. Practically, this meant identifying outcome measures, collecting data, analyzing the results, and modifying the intervention when the outcome fell below benchmarks. For example, the risk management process starts with screening of all patients for risk behaviors (self-injury, suicidality, assaultiveness, problem sexual behavior, falls, elopement), and then establishing triggers and thresholds for further review and interventions regarding behaviors of concern (e.g., two assaultive incidents in one week, or two episodes of restraint use in one week). The process then moves to data reporting, maintaining a database, and communicating findings to appropriate committees within the hospital, including

identifying when to present cases to either the facility's local division leadership or broader hospital review committees.

Thus, databases were created that tracked information related to the various functions of the hospital. To achieve adherence to optimal standards of practice, many clinical tasks and functions were routinized.

The use of data to inform decision-making also made it possible to monitor progress on identified goals such as minimizing the use of restraint and seclusion, and managing risk, for instance by ensuring that patients presenting the greatest risk received the commensurate resources, e.g., sensory integration services, behavioral support plans, individual psychotherapy, consultations by experts, etc. These changes have implications for the philosophical goals of state funded inpatient care from sheltering and treating those who are acutely ill to promoting optimal mental health and adaptive functioning.

### **Sustainability**

The most important sustainable changes in practice influenced by the DOJ have been structural changes. These include the development of a risk management infrastructure, different levels of review committees for complex clinical cases, auditing processes and utilization of audit findings, changes in treatment planning processes, and medical record documentation, to mention a few. These would subsequently lead to sustainable policy changes that would drive culture change and improvement in treatment.

On the other hand, changes that depend on staff or budgetary allocations are harder to maintain. When state financial allocations are leaner, available funds may not be enough to hire or replace key staff or those with specialized training such as behavioral psychologists or neuropsychologists. Likewise, decreased funding negatively affects resources for developing appropriate discharge options for patients with complicated needs.

### **Discussion**

In contrast to Geller and Lee<sup>4</sup> who have documented the challenges and adverse consequences of investigations of state hospital facilities by the U.S. Department of Justice, we have proposed to describe the experience of our hospital, attempting to identify the positive as well as negative outcomes of a DOJ investigation.



Unlike CMS and TJC, the standards of practice to which the DOJ holds hospitals differ from what most practitioners would consider the current standards of practice. To cite just a few examples, it should be noted that neither positive behavioral support planning nor antipsychotic monotherapy are considered standards of practice across the country. Rather, these interventions may be thought of as vanguard interventions. Although they have a modicum of empirical support, they have not risen to the rank of generally accepted empirically supported interventions. In the Cochrane Library database, behavioral interventions to reduce aggressive behavior in individuals with intellectual disabilities are listed as a “promising approach.”<sup>28</sup> The Cochrane Library database does not contain a review of behavioral interventions to reduce aggressive behavior in individuals with major psychiatric disabilities. This is not to discount the current understanding that psychological interventions, including behavior therapies, are useful adjuncts in the management of behavioral excesses, but they are not considered generally accepted professional standards of care as postulated by the DOJ. The DOJ’s enhanced focus on psychological and behavioral interventions during their investigation of CVH was notable. It was unclear, however, if this was influenced by the particular interests and sensibilities of the designated consultant as opposed to professional consensus.

In a Cochrane review of antipsychotic monotherapy, Ortiz-Orendain *et al.*<sup>29</sup> concluded, “We found very low-quality evidence that a combination of antipsychotics may improve the clinical response. We also found very low-quality evidence that a combination of antipsychotics may make no difference at preventing participants from leaving the study early, preventing relapse and or causing more serious adverse events than monotherapy” (Ref. 29, p. 25). These conclusions hardly constitute a wholehearted endorsement of either antipsychotic monotherapy or polytherapy.

The weak evidence in support of these interventions does not negate their value. In our opinion, these recommendations are in fact quite valuable. The challenge we encountered was that interventions such as these were advanced as state of the art interventions by consultants who were not experts in the field. This led to resentment on the part of hospital clinicians who were already struggling with outsiders criticizing their work and their good will.

The data collection and documentation requirements imposed by the DOJ framework resulted in clinicians spending considerably more of their time with paperwork and less time interacting with the patients in their care. This also led to considerable stress on clinicians and hospital administrators and had the consequence that many valuable employees left the hospital. Most clinicians who work in public mental health facilities do so motivated by a sense of service and commitment to an underprivileged population and do so with smaller financial compensation than in the private sector. This made it more difficult for them to accept the DOJ consultants’ challenging of their work.

The most valuable attribute of the DOJ approach has been the systematic use of data to inform practice. Our hospital has adopted this conceptual approach with positive results in many areas. The clinical and risk management infrastructures have also been very useful at measuring and monitoring implementation of various initiatives aimed at improving quality of care and minimizing risk. The vanguard interventions proposed by the DOJ consultants (e.g., positive behavioral support planning) have also clearly benefited many individual patients and have now been incorporated in the clinical work of the hospital. The development of a behavioral intervention service that was available to consult to all units was a positive outcome, but this service is dependent on the availability of sufficiently trained and experienced staffing resources.

In all, the DOJ investigation yielded significant benefits to the hospital but did so at considerable cost to the state, the hospital, and its employees. The preferred approach to implement such changes would be consultative and collaborative rather than an adversarial one in which many resources are diverted to direct and indirect litigation costs.

## References

1. Civil Rights of Institutional Persons Act, 42 U.S.C. § 1997 *et Seq.* 1980
2. U.S. Department of Justice Investigation of Connecticut Valley Hospital. 2007. Available from: [https://www.cga.ct.gov/ph/tfs/20190426\\_CVH%20Whiting%20Task%20Force/20070806\\_DOJ%20CRIPA%20Investigation%20of%20CVH/DOJ%20CRIPA%20Investigation%20of%20CVH%20August%206,%202007.pdf](https://www.cga.ct.gov/ph/tfs/20190426_CVH%20Whiting%20Task%20Force/20070806_DOJ%20CRIPA%20Investigation%20of%20CVH/DOJ%20CRIPA%20Investigation%20of%20CVH%20August%206,%202007.pdf). Accessed January 2, 2023
3. Connecticut Valley Hospital Settlement Agreement. 2009. Available from: [https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/CVH\\_settle\\_01-20-09.pdf](https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/CVH_settle_01-20-09.pdf). Accessed January 2, 2023
4. Geller J, Lee L. United States Department of Justice findings letters in psychiatric hospital CRIPA cases: An aid or a distraction? *J Am Acad Psychiatry Law.* 2013 Jun; 41(2):174–90

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5. Ozarin L. Diseases of the mind: highlights of American psychiatry through 1900. National Institute of Health [Internet]; 2006. Available from: <https://www.nlm.nih.gov/hmd/diseases/credits.html>. Accessed August 24, 2022
6. Deutsch A. Shame of the States. New York: Harcourt, Brace and Company; 1948
7. Goffman E. Asylums Essays on the Social Situation of Mental Patients and Other Inmates. New York: Anchor Books, Doubleday and Company; 1961
8. Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq*, § 7 (1964)
9. National Mental Health Act of 1946, H.R. 4512, 79th Cong. (1946)
10. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971)
11. Disability Justice. Wyatt v Stickney [Internet]. Available from: <https://disabilityjustice.org/wyatt-v-stickney/>. Accessed January 2, 2023
12. United States v. Solomon, 419 F. Supp. 358 (D. Md. 1976)
13. United States v. Solomon, 563 F.2d 1121 (4th Cir. 1977)
14. United States v. Mattson, 600 F.2d 1295 (9th Cir. 1979)
15. Holt K. When Officials Clash: Implementation of the Civil Rights of Institutionalized Persons Act. Westport, CT: Praeger Publishers; 1998
16. Olmstead v. L.C., 527 U.S. 581 (1999)
17. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 (1990)
18. Sloan L, Gulrajani C. Where we are on the twentieth anniversary of *Olmstead v. LC*. J Am Acad Psychiatry Law. 2019 Dec; 47(4): 408–13
19. Baskerville B. A Psychiatric Patient Spends Final Month in Solitary Torment. Los Angeles Times Archives [Internet]; 1997 July 13. Available from: <https://www.latimes.com/archives/la-xpm-1997-jul-13-mn-12216-story.html#:~:text=It%20was%20June%2029%2C%201996%2C%20the%20end%20of,of%20more%20than%20110%20hours-4%201%2F2%20days%20straight>. Accessed August 23, 2022
20. Weiss EM. Deadly restraint: A Hartford Courant investigative report (five-part series). Hartford Courant [Internet]; 1998 October 11–15. Available from: <https://www.charlydmiller.com/LIB05/1998hartforddata.html>. Accessed August 23, 2022
21. Freedom From Restraint Act of 1999, S. 736, 106th Cong. (1999)
22. Department of Justice Activities Under the Civil Rights of Institutionalized Persons Act Fiscal Year. 2015. Report to Congress Re CRIPA-fy15. Available from: <https://www.justice.gov/crt/page/file/933876/download>. Accessed January 2, 2023
23. AkitaBox. Joint Commission 101: What is “Deemed Status” and Who Grants it? [Internet]; 2020 Jan 21. Available from: <https://home.akitabox.com/blog/deemed-status-and-joint-commission/>. Accessed January 2, 2023
24. Centers for Medicare and Medicaid Services. Conditions for Coverage (CFCs) and Conditions of Participation (CoPs) [Internet]. Available from: <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFsAndCoPs>. Accessed January 2, 2023
25. Youngberg v. Romeo, 457 U.S. 307 (1982)
26. National Association of State Mental Health Program Directors. Six Core Strategies for Reducing Seclusion and Restraint Use [Internet]; 2006. Available from: <https://www.nasmhpd.org/sites/default/files/2022-08/Consolidated%2520Six%2520Core%2520Strategies%2520Document.pdf>. Accessed January 2, 2023
27. Dike CC, Lamb-Pagone J, Howe D, *et al*. Implementing a program to reduce restraint and seclusion utilization in a public-sector hospital: Clinical innovations, preliminary findings, and lessons learned. Psychol Serv. 2021 Nov; 18(4):663–70
28. Ali A, Hall I, Blickwedel J, *et al*. Behavioural and cognitive-behavioural interventions for outwardly directed aggressive behaviour in people with intellectual disabilities. Cochrane Database Syst Rev. 2015 Apr; 2015(4):CD003406
29. Ortiz-Orendain J, Castiello-de Obeso S, Colunga-Lozano LE, *et al*. Antipsychotic combinations for schizophrenia. Cochrane Database of Systematic Reviews. 2017 Jun;(6):CD009005